Arizona Health Care Cost Containment System

September-October, 2002

ENCOUNTER KEYS

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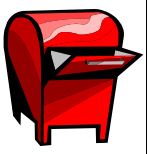
AHCCCS ENCOUNTER OPERATIONS UNIT



P.O. Box 25520

Phoenix, AZ 85002-5520

Mail Drop #8500

Fax: 602-417-4725

Internet:www.ahcccs.state.az.us/publications

For Technical Assistance contact:

Peggy Brown (602) 417-4662

Ester Hunt (602) 417-4140

FREEDOM TO WORK ELIGIBILITY & RATE CODES

The New Freedom to Work Eligibility and Rate Codes

Please note, since the Freedom to Work program has been delayed, the new eligibility key codes and rate codes are not scheduled to be effective until January 2003. You will be receiving additional information regarding the new eligibility key codes and rate codes for this program at a later date.

CORRECTION TO WEBSITE FOR ADHS/DBHS

In the May/June 2002 Encounter Keys the AHCCCS Behavioral Health Services Guide was incorrectly listed as an Arizona Department of Health Services publication. The guide is published by AHCCCS, Office of Managed Care, Behavioral Health Unit. Also, the web address was listed incorrectly. The guide can be accessed at http://www.ahcccs.state.az.us/Publications/BehavioralHealth/behavioralhealth_index.asp

TIER LEVELS

Encounters with a **36X REVENUE CODE** for inpatient surgical cases need to include ICD-9 procedure codes. When surgical procedure codes are not included or if the surgical procedure code is on the "Excluded Surgery List'', encounters are valued as ROUTINE instead of SURGICAL tier. Rate-setting, capitation and Reinsurance reimbursement may be impacted when ICD-9 procedure codes are missing from a 36X Revenue code encounter.

AHCCCS, OFFICE OF MANAGED CARE, ENCOUNTER OPERATIONS UNIT
Encounter File Processing Schedule

	Sat	Sat	Sat	Sat	Sat	Sat
Deadline for Corrected Pended Encounter and	10/05/02	11/09/02	12/07/02	01/04/03	02/08/03	03/08/03
New Day File Submission to AHCCCS	5:00 AM	5:00 AM	5:00 AM	5:00 AM	5:00 AM	5:00 AM
Work Days for AHCCCS	6	6	6	6	6	6
Encounter Pended and Adjudication Files	Tue	Tue	Mon	Mon	Tue	Mon
Available to Health Plans	10/15/02	11/19/02	12/16/02	01/13/03	02/18/03	03/17/03
Work Days for Health Plans	18	12	13	18	13	14

Note:
1. This schedule is subject to change. If untimely submission of an encounter is caused by an AHCCCS schedule change, a sanction against timeliness error will not be applied.
2. Health Plans are required to correct each pending encounter within 120 days.
3. On deadline days, encounter file(s) must arrive at AHCCCS by 5:00 a.m. Files arriving after 5:00 a.m. will be processed the following cycle.

SYSTEM UPDATES

Modifier Availability

Procedure code 73725 (Magnetic Resonance Angiography, lower extremity, with or without contrast material(s)) may be reported with modifier 26 (Professional Component) and TC (Technical Component) .

Effective on and after January 01, 2001, surgical procedure 46934 (Destruction of Hemorrhoids, any method; internal) can be reported with modifier 58 (Staged or related procedure or service by the same physician during the postoperative period).

Surgery Added to Hospital Setting

Effective on and after January 01, 2001, surgical procedure 50545 [Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)] can be reported with an inpatient hospital setting place of service (21).

Dialysis Codes

Effective on and after January 01, 2001, physicians (provider type 08) and osteopaths (provider type 31) may report the following code A4700 (Standard Dialysate Solution, Each).

Hospital Outpatient PPS Codes

The transitional passthrough device category codes, C1000 to C9999, are now available for reporting. The effective dates of service vary, please see each code for exact date.

Cancer Screening

HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) is available effective on and after January 01, 2001.

New Age Limits Set for Durable Medical Equipment

The age limit has been lowered to 3 years of age on HCPCS code E0784 (External ambulatory infusion pump, insulin).

Codes Added for Pharmacy Providers

Effective with dates of service on and after January 1, 2000 provider type 03, Pharmacy, can report the following HCPCS:

- A7000 Canister, disposable, used with suction pump, each
- A7001 Canister, non-disposable, used with suction pump, each
- A7002 Tubing, used with suction pump, each
- A7003 Administration set, with small volume nonfiltered pneumatic nebulizer, disposable
- A7004 Small volume nonfiltered pneumatic nebulizer, disposable
- A7005 Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable
- A7006 Administration set, with small volume filtered pneumatic nebulizer
- A7007 Large volume nebulizer, disposable, unfilled, used with aerosol compressor
- A7008 Large volume nebulizer, disposable, prefilled, used with aerosol compressor
- A7009 Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer
- A7010 Corrugated tubing, disposable, used with large volume nebulizer, 100 feet
- A7011 Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet
- A7012 Water collection device, used with large volume nebulizer
- A7013 Filter, disposable, used with aerosol compressor
- A7014 Filter, non-disposable, used with aerosol compressor or ultrasonic generator
- A7015 Aerosol mask, used with DME nebulizer
- A7016 Dome and mouthpiece, used with small volume ultrasonic nebulizer
- A7017 Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen
- A7018 Water, distilled, used with large volume nebulizer, 1000 ml
- A7019 Saline solution per 10 ml, metered dose dispenser, for use with inhalation drugs
- A7020 Sterile water or sterile saline, 1000 ml, used with large volume nebulizer
- A7501 Tracheostoma valve, including diaphram, each
- A7502 Replacement diaphram/faceplate for tracheostoma valve, each
- A7503 Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system each
- A7504 Filter for use in a tracheostoma heat and moisture exchange system, each
- A7505 Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each
- A7506 Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type, each
- A7507 Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each
- A7508 Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each
- A7509 Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each
- A9900 Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
- A9901 DME delivery, set up, and/or dispensing service component of another HCPCS code

Codes Added for MD and DO

Effective with dates of service on and after January 1, 1999 provider types 08, MD-Physician, and 31, DO-Physician Osteopath, can report HCPCS:

- Q0183 Dermal tissue, of human origin, with and without other bioengineered or processed elements; but without metabolically active elements, per square centimeter
- Q0184 Dermal tissue, of human origin, with and without other bioengineered or processed elements; but with metabolically active elements, per square centimeter
- Q0185 Code deleted effective March 31, 2002, use J7340 Dermal and epidermal, tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter

Category of Service Assigned

Effective July 1, 1999 to June 30, 2001 the following HCPCS codes have been assigned category of service 13-Radiology;

- G0163 Posterior emission tomography (PET), whole body, for recurrence of colorectal metastatic cancer
- G0164 Posterior emission tomography (PET), whole body, for staging and characterization of lymphoma
- G0165 Posterior emission tomography (PET), whole body, for recurrence of melanoma or melanoma metastatic cancer

Procedure Codes Added for Specified Provider Types

Effective January 01, 2001, procedure code 41899 (Unlisted Procedure, Dentoalveolar structures) has been added to Provider type 43, Ambulatory Surgery Center, and reimbursement is at ASC Level 1.

Effective for dates of service on and after July 1, 2001 Podiatrists, provider type 10, can report:

- 20670 – Removal of implant; superficial, (e.g., buried wire, pin or rod)
- 97601 Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
- 97602 Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Effective for dates of service on and after July 1, 2002 Registered Nurse Practitioners, provider type 19, can report the following procedure codes:

- 95115 Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
- 95117 Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections

Base Rate Increased

The anesthesia basic value has been increased on the following HCPCS codes:

- 01924 Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; not otherwise specified; increased to 6 units
- 01925 Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; carotid or coronary; increased to 8 units
- 01926 Anesthesia for therapeutic interventional radiologic procedures involving the arterial system; intracranial, intracardiac, or aortic; increased to 10 units
- 01932 Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular; increased to 7 units
- 01933 Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not to include access to the central circulation); intracranial; increased to 8 units
- 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery) increased to 5
- 01968, Cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure) increased to 3 base units

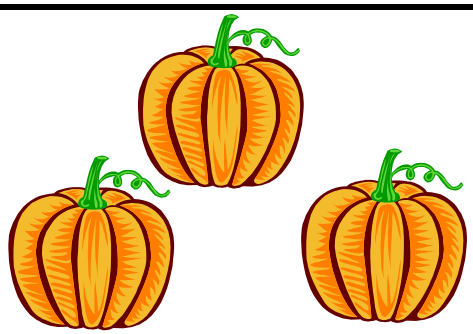
PLACE OF SERVICE ADDITIONS

01/01/2002	24546 – Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; with intercondylar extension	Outpatient Hospital-22
01/01/2002	29405 – Application of short leg cast (below knee to toes)	Skilled Nursing Facility-31; Nursing Facility-32
01/01/2002	29425 – Application of short leg cast (below knee to toes); walking or ambulatory type	Skilled Nursing Facility-31; Nursing Facility-32
01/01/2002	88108 – Cytopathology, Concentration Technique, Smears& Interpretation (e.g., Saccomanno technique)	Ambulatory Surgical Center-24
01/01/2002	68761 Closure of the lachrymal punctum; by plug, each	Nursing Facility-32
01/01/2002	96150 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysicological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	Inpatient Hospital-21
01/01/2002	96151 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysicological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; reassessment	Inpatient Hospital-21
01/01/2002	96152 Health and behavior intervention, each 15 minutes, face-to-face; individual	Inpatient Hospital-21
01/01/2002	96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	Inpatient Hospital-21
01/01/2002	96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)	Inpatient Hospital-21
01/01/2002	96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)	Inpatient Hospital-21
01/01/2002	K0186 (Chin Strap Used With Positive Airway Pressure Devise	Home-12
01/01/2002	K0184 (Nasal Single Piece Interface, Replacement for Nasal)	Home-12
07/01/2001	92977 (Thrombolysis, coronary; by intravenous infusion)	Emergency Room, Hospital-23
07/01/2001	47511 (Introduction of percutaneous transhepatic stent for internal and external biliary drainage)	Outpatient Hospital-22
01/01/2001	27630 (Excision of lesion of tendon sheath or capsule, leg and/or ankle) and 27635 (Excision or curettage of bone cyst or benign tumor, tibia or fibula)	Office-11
01/01/2000	14061 (Adjacent tissue transfer or rearrangement, eyelids, nose, ears, and/or lips; defect 10 sq cm or less)	Office-11
09/01/2001	90801 (Psychiatric Diagnostic Interview Examination)	Home-12
01/01/1995	K0186 (Chin strap used with positive airway pressure device)	Office-11; Home-12; Outpatient Hospital-22; Skilled Nursing Facility-31; Nursing Facility-32; State or Local Public Health Clinic-71; Rural Health Clinic-72
01/01/1995	K0184 (Nasal single piece interface, replacement for nasal application device, pair or single piece interface)	Office-11; Home-12; Outpatient Hospital-22; Skilled Nursing Facility-31; Nursing Facility-32; State or Local Public Health Clinic-71; Rural Health Clinic-72

DIAGNOSIS AGE LIMITS

For the following diagnosis codes please note that for most, the diagnosis is related to an acute condition affecting a fetus or newborn. These acute conditions are inappropriate for reporting chronic residual effects. Please verify that the provider is reporting the acute condition or reason for the visit.

Pri DX Code	Description	Minimum Age	Maximum Age
257	Testicular Hyperfunction	10	55
367	Hypermetropia	0	20
740.1	Craniorachischisis	0	1
760	Fetus Or Newborn Affected By Maternal Condition	0	1
760.5	Maternal Injury Affecting Fetus Or Newborn	0	1
760.7	Unspecified Noxious Substance Affecting Fetus	0	1
761.1	Premature Rupture Of Membranes Affecting Fetus	0	1
761.2	Oligohydramnios Affecting Fetus Or Newborn	0	1
761.3	Polyhydramnios Affecting Fetus Or Newborn	0	1
762.1	Other Forms Of Placental Separation And Hemorrhage	0	1
763.1	Other Malpresentation, Malposition, And Disproportion	0	1
763.4	Cesarean Delivery Affecting Fetus Or Newborn	0	1
763.83	Abnormality In Fetal Heart Rate Or Rhythm	0	1
764.00	Light-For-Dates Without Mention Of Fetal Malnutrition	0	1
764.05	"Light-For-Dates" Without Mention Of Fetal Malnutrition	0	1
764.9	Fetal Growth Retardation, Unspecified	0	1
765.10	Other Preterm Infants, Unspecified (Weight)	0	1
765.18	Other Preterm Infants, 2,000-2,499 Grams	0	1
767.0	Subdural And Cerebral Hemorrhage Due To Birth	0	1
767.6	Injury To Brachial Plexus Due To Birth Trauma	0	1
768.3	Fetal Distress First Noted During Labor	0	1
769	Respiratory Distress Syndrome In Newborn	0	1
770.8	Other Newborn Respiratory Problems	0	1
773.0	Hemolytic Disease Due To Rh Isoimmunization	0	1
774.6	Unspecified Fetal And Neonatal Jaundice	0	1
779.3	Feeding Problems In Newborn	0	1
779.9	Unspecified Condition Originating In The Perinatal Period	0	1
V20.2	Routine Infant Or Child Health Check	0	20
V30.0	Single Liveborn, Born In Hospital	0	1
V30.2	Single Liveborn, Born Outside Hospital And Not Hospitalized	0	1
V31.1	Twin Birth, Mate Liveborn, Born Before Admission	0	1
V72.0	Examination Of Eyes And Vision	0	21



DILEMMAS

For the months of September and October the following error code conditions are not subject to sanction.

S385 – Service Units Exceed Maximum Allowed (80000 procedure codes and service units less than twice the limit).

P015 - Service Provider Type Invalid For Uniform Billing Form

R295– Medicare Reported But Not Indicated (For Part B on facility encounters**)**

S841 - ASC Procedure Code Is Not Covered

S842 - ASC Procedure Code is Not Classified

NEW ERROR CODES

The following new edits were added and set to "Hard" effective October, 2002. Typically Contractors are notified 90 days before an edit is set to "Hard". However, because these edits were implemented to correct existing edit logic, prior notification could not be provided.

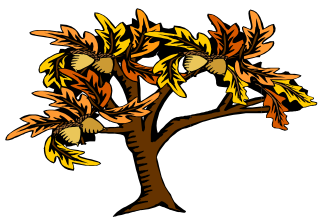
Z796 – Near Dupe, DME supplies service overlap

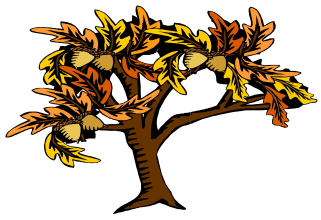
Z797 – Near Dupe, DME supplies service overlap, different health plans

UB-92 PATIENT STATUS UPDATE

CODE	DESCRIPTION
01	Discharged To Home Or Self Care
02	Discharge/Transfer To Another Hospital
03	Discharge/Transfer To SNF
04	Discharge/Transfer To ICF
05	Discharge/Transfer To Other Type Institution
06	Discharge/Transfer To Home Health Care
07	Left Against Medical Advice
08	Discharge/Transfer To Home IV Provider
09	Admitted As An Inpatient To This Hospital
20	Expired
30	Still Patient
40	Expired At Home
41	Expired At Medical Facility
42	Expired/Place Unknown
50	Hospice - Home
51	Hospice - Medical Facility
61*	Discharged/Transferred Within This Institution To Hospital Based Medicare Approved Swing Bed
62*	Discharge/Trans To Rehab Facility Including Rehabilitation
63*	Discharge/Transferred To LTC Hospital
64	Discharged/Transferred To A Nursing Facility Certified
71*	Discharge/Transferred/Referred To Another Institution
72*	Discharge/Transferred/Referred to this Institution O/P

*Effective date October 01, 2001



AHCCCS MEDICARE RESEARCH REQUEST FORM

AHCCCS Medicare Research Request form may be used by Health Plans and providers to report new or changed Medicare information that is not currently on the AHCCCS system. The new information will be verified and updated if appropriate.

The form should be faxed to AHCCCS/MFIS at 602-253-4807 or contact Cecilia Ruiz in MFIS at 602-417-4599 should any questions arise regarding the form.

AHCCCS MEDICARE RESEARCH REQUEST FORM

To help us research member Medicare data, please complete this form, sign, date and return it.

INSTRUCTIONS FOR COMPLETION: Please print or type. Fill as much information as possible in the spaces below. Fax completed forms to **AHCCCS/MFIS at (602) 253-4807.**

RECIPIENT MEDICARE INFORMATION

1. AHCCCS ID #: _____
2. NAME: _____
3. DOB: _____
4. SOCIAL SECURITY NUMBER: _____
5. MEDICARE CLAIM NUMBER: _____
6. PART A BEGIN DATE: _____ / PART A END DATE: _____
7. PART B BEGIN DATE: _____ / PART B END DATE: _____
8. SIGNATURE OF PERSON COMPLETING FORM: _____
9. HEALTH PLAN/PROGRAM CONTRACTOR/PROVIDER: _____
10. TELEPHONE #: _____
11. DATE: _____



ERROR CODE S345 – PROCEDURE NOT AVAILABLE ON DATE OF SERVICE

The following procedure codes are not accepted by AHCCCS because they are no longer covered services or must be reported using a different code.

Code	Description	Coverage Code	Effective Date
A4590	Special Casting Material (e.g. Fiberglass)	04	09/30/2001
B4084	Gastrostomy/Jejunostomy Tubing	03	04/01/2002
D9240	Intravenous Sedation	03	04/01/2000
J7196	Other Hemophilia Clotting Factors, (e.g., anti-inhibitor)	03	04/01/2000
00955	Neuraxial Analgesia/Anesthesia for Labor Ending in a Vaginal Delivery	03	04/01/2002
78990	Provision of Diagnostic Radiopharmaceutical(s)	04	01/01/1994
90745	Hepatitis B Vaccine, Adolescent/High Risk Infant Dosage	03	04/01/2000

Note:

03	Covered Service/Use Other Code
04	Not Covered Service/Code Not Available

APC NEWS

HOT TRANSMITTAL: Take a hard look at AB-02-072 as it relates to self administered medications. (The name of the transmittal is misleading: Medicare Payment for Drugs and Biologicals Furnished Incident to a Physician's Service. But it applies to outpatient service areas: ER, Observation, hospital based clinics and Outpatient Surgery.)

Things to look for:

1) Definition of "usually" self administered: Means more than 50% of the time for all Medicare beneficaries who use the drug. This is being applied when determining if it is 'usually' self administered.
2) Drugs administered intravenously are presumed to not usually be self administered.
3) Intramuscular (IM) injections are also presumed to not usually be self administered. HOWEVER, frequency and duration of the need for the drug are factors in determining if a drug is self administered.
4) Oral drugs, suppositories, and topic medications are usually considered self administered and not covered by Medicare. These must be collected from the patient.
5) Each Carrier & Intermediary must report to CMS every 6 months its complete list of injectable drugs that are excluded. Each individual contractor must make its own individual decision on each drug.
6) Each carrier must also make a decision on the medical necessity of the drug and the routing of administration. Discretion is allowed at the local FI/carrier level. They must post on their web sites the results of the application of the criteria and notify providers at the earliest opportunity.

Watch for this transmittal to be further developed in the near future. Expect variation in interpretation with each FI and carrier. It was effective 8-1-02. **AHCCCS covers self-administered drugs (Revenue Code 637).**